

CONSULTING DERMATOLOGIC SPECIALISTS

Forrest C. Brown, M.D., P.A.

7777 Forest Lane Suite C-528

Dallas, TX 75230

Phone: (972) 566-4537 Fax: (972) 566-6018

NOTICE AND ACKNOWLEDGEMENT OF PRIVACY POLICIES AND PROCEDURES

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

As required by the Health Information and Portability and Accountability Act of 1996 (HIPAA), Consulting Dermatologic Specialists may not use or disclose your personal health information without your authorization.

The Practice has policies and procedures to comply with HIPAA law. Every attempt has been made to keep the process for patients and staff as efficient as possible. However, the requirements are extensive and take time, effort and cooperation to process required tasks.

All patients are presented with certain notices and must sign certain forms. Depending on the course of treatment, some patients may be required to sign additional forms. The following is a summary of the most common notices and forms.

Notices of Privacy Practices-This notice describes how medical information about you may be used and disclosed and how you get access to this information.

Authorization for Use or Disclosure of Protected Health Information-The Practice may not use or disclose your health information for purposes other than health treatment, payment or health care operations, without your authorization. Your signature on this form indicates that you are giving permission to the practice for use and disclosure of the health information listed on the form, for purpose(s) listed on the form, to the people/organization(s) listed on the form. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning to the office.

Complaint-You have the right to make a complaint about the Practice's privacy policies, procedures or actions. The Practice will not engage in any discriminatory or other retaliatory behavior against you because of your complaint.

Request to Amend Protected Health Information-You have the right to request that health information that requires you be amended if you believe that it is incorrect or incomplete. The Practice will review your request and either grant your request or explain the reason why it will not be granted. In the event that your request is not granted, you have the right to submit a statement of disagreement that will accompany the information in question for all future disclosures.

Request for Inspection of protected Health Information-You have a right to request the opportunity to inspect and copy health information that pertains to you. The Practice will evaluate your request and will either grant it or explain the reason why the request will not be granted. In the event that your inspection request is not granted, you may request that someone other than the person who originally denied the request review the decision. If you request copies of your medical record, the Practice reserves the right to charge you a reasonable fee for the expenses associated with copying the requested information.

Request for Accounting of Disclosures of Protected Health Information-You have the right to request an accounting of all non-routine disclosures of health information that pertains to you. Disclosures of health information associated with treatment, payment and healthcare operations or with prior patient authorizations will not be accounted for.

Confidential Channel Communication Request-You have a right to request the communications concerning your personal health information be made through confidential channels. The Practice will do its best to accommodate all reasonable requests.

Designation of Personal Representation-You have a right to nominate one or more persons to act on your behalf with respect to the protection of health information that pertains to you by making this request, you are informing the Practice of your wish to designate the named person(s) as your personal representative. You may revoke this designation at any time by signing and dating the revocation of your copy of this form and returning it to this office.

Acknowledgement of receipt of Notice of Privacy Practices:

I acknowledge that I have received and read the above Notice of privacy Policy and Procedures and have had any questions regarding this notice answered to my satisfaction.

PATIENT/PATIENT REPRESENTATIVE SIGNATURE

DATE

PRINTED NAME

DATE

Contact Information

It is permissible to contact me at (please list phone number(s) on the appropriate line):

Home: () _____ Work: () _____ Cell: () _____

It is permissible to leave voice messages at: ___Home ___Work ___Cell

It is permissible to leave messages with other people who may answer at: ___Home ___Work

